FORM 115
ORIGINAL

REQUISITION FOR STOREROOM SUPPLIES

SERIAL No. 3975

STOREKEEPER'S NUMBER _____

DATE DELIVERED _____

DATE _____ 19____

To the BUSINESS MANAGER:

I request delivery of the following articles to _____ Department as listed under column headed "Quantity Wanted."

[SIGNED] _____

53698 4-57 250M TRIP ⓢ SPO

QUANTITY		DESCRIPTION	REMARKS	√	DELIVERED QUANTITY	√
WANTED	UNIT					

I hereby approve this requisition.

_____
Approving Officer's Signature

_____
Approving Officer's Title

√
Receipt Compared

TO THE ACCOUNTING DEPARTMENT:

I have delivered the articles ordered as noted in the column headed "DELIVERED."

_____
Storekeeper

PROCEDURE FOR KEEPING DAILY WARD REPORT BOOK

1.0 A well kept Daily Ward Report Book enables the employees on all three shifts to be informed about the ward activities and the behavior of the patients during the 24 hour period. It is particularly helpful for the Technician who has been off duty for several days to catch up with ward activities.

2.0 The Technician in charge of each shift is responsible for the accurate recording of ward events.

3.0 ALL employees in the ward unit should read the Daily Ward Report Book when they come on duty. It should be immediately available to the Physician, the Supervisor, and the Superintendent of Nurses.

4.0 Recorded events should read as follows:

4.1 Date -- employees and their classification (on every shift)
employees that are absent
employees (Trainees) attending classes

4.2 Ward check by Charges at change of every shift.

A. Day Shift Only: Rated Capacity
Number of beds
Excess
Number of vacant beds

B. Patient population at beginning of shift.

C. Name patients and their status that have been added or removed during shift.
D. By transfer
E. Returned from leave
F. Returned from visit
G. Returned from unauthorized leave
H. Guest
I. By vacation
J. By LOA
K. By unauthorized leave
L. By hospitalization
M. By discharge
N. By death
O. Sleeping off ward

4.3 Record in detail, any activity or change of scheduled routine, i.e.:

A. patients off ward
B. patients at school, clinics, social service or specific therapy.
C. visitors to patient whether on ward or if off - record relationship to patient.
D. all Special Incident Reports that were made, the nature thereof and everyone involved.
E. when Doctor is called and what response was.
F. any Restraint or Seclusion procedure carried out -- record in detail, on proper forms in patient's folder stating reason for restraint and Doctor's name ordering same.
G. a change in patients medication or any new medical order.

PROCEDURE FOR KEEPING DAILY WARD REPORT BOOK - cont.

H. any new procedure or directive received on ward.
I. if any patient has been disciplined - describe the offense and the discipline which was enforced and how long the discipline is to be in effect. Also by whom this was ordered - Doctor, S.P.T. or ?.
J. any unusual happening to patient or employee (accident to employee included here).
K. any request made for emergency repairs - and when completed.
L. visitors names (other than those visiting patients).

4.4 Population

DAILY WARD REPORT BOOK

SAMPLE (No vacant lines to be left between lines) SAMPLE

Friday, August 1, 1958 — 6:45 a.m. to 3:15 p.m. — 9:00 to 5:30 p.m.
On Duty: M. Smith, P.T.II, O. Jones, P.T. - J. Hill and O. Rose, Trainees
B. Black, P.T. - Absent

52	Capacity	0	Hospital
58	Population	2	Employed on Ward
60	Beds	54	Employed Off Ward
56	Patients beginning of shift	1	Non-worker
57	Patients end of shift	1	Def. visit
2	pink slips beginning of shift	57	Actual count
1	pink slip end of shift	2	Vacant beds

7:00 a.m. - 28 details off ward
7:00 a.m. - Personnel check by (Supervisor)
9:00 a.m. - Sue Jones #12345 - fell while having an epileptic seizure opening an old wound at base of skull. Dr. X. called - ordered patient to hospital, 5 stitches were taken. Patient returned to ward. Doctor ordered 3 da. bed rest. Medication changed. Special Incident made.
9:30 a.m. - Brown, Jane #6644 to Eye Clinic with O. Jones - returned 10:00 a.m.
11:00 a.m. - Doe, Joan #45067 - returned from Def. visit
11:30 a.m. - Supervisor _____ _____ on ward.
1:30 p.m. - 13 patients to Activity Center Party with O. Jones
2:00 p.m. - Dr. _____ _____ on ward.
2:30 p.m. - Emergency repair - reported refrigerator out of order.
3:00 p.m. - 13 patients returned from Activity Center
Keys and lanterns count.
Ward checked with Mrs. Hill, P.T.I

(Always draw lines between shifts.)

M. Smith, P.T.II

Friday, August 1, 1958 2:45 p.m. to 11:15 p.m.
On duty: V. Hill, P.T.I; J. Gray, P.T.T.
Supervisor _____ _____ checked personnel

58	Population	0	Hospital
60	Beds	57	Actual count
57	Patients beginning of shift	1	Definite leave
57	Patients end of shift	56	Sleeping
1	Pink slip beginning of shift	4	Empty beds
1	Pink slip end of shift		
2	Vacant beds		

3:30 p.m. - Referigerator repaired - 26 details returned to ward
4:00 p.m. - 2 details returned to ward
5:35 p.m. - Supervisor _____ _____ on ward. - Brown, Ann #12345 sleeping at Dr. Frederickson's.
5:45 p.m. - Medications given as ordered.
Clothes did not come back from laundry.
1 set of keys and 2 lanterns checked.
Ward checked with C. Brown, P.T.I

Mrs. Hill, P.T.I

Friday, August 1, 1958 11:00 p.m. to 7:00 a.m.
On duty: G. Gray
11:00 p.m. - Personnel Check by Supervisor _____ _____.

58	Population	1	pink slip
57	Patients at beginning of shift	57	Actual count
57	Patients at end of shift		

Brown, Ann #12345 sleeping at Dr. Frederickson's.
4:00 a.m. - Supervisor _____ _____ on ward.
Details day off: Sue Brown and J. Black.
7:00 a.m. - Medications given as ordered.
Ward checked with M. Smith, P.T.II

C. Brown, P.T.I

DIRECTIONS FOR MAKING OUT PSYCHIATRIC TECHNICIANS DAILY REPORT

Refer to SAMPLE - page 51 B.

Explaination of Items

1.0 V & D.V.: These forms (Yellow and Pink slips) are initiated in Social Service and are held on the ward during the time a patient is out on a Visit (Yellow) or a Definite Visit (Pink). The number of Yellow and Pink slips being held (representing the number of patients out on V. or D.V.) are counted and reported here.

2.0 No. of Patients: This figure reflects the total number of patients assigned to the ward. (i.e. including patients hospitalized or sleeping off the ward. It doesn't include patients being guested on the reporting ward.)

3.0 No. of Beds: This figure reflects the number of beds the ward is assigned. This figure changes only upon the order of the Superintendent of Sonoma State Hospital, or the Associate Superintendent.

4.0 Vacant Beds: This figure is the number of beds not in use by assigned patients, thus it represents the difference between the No. of Beds and the No. of Patients.

5.0 Excess Patients: This figure represents the number of patients assigned to the ward over and above the No. of Beds assigned. (i.e. the wards maximum population possible is the same as the No. of Beds, thus any patients assigned to the ward after this population figure is reached are in Excess of the maximum population allowed.)

6.0 Hospitalized: This figure reflects the number of assigned patients that are in the "Hospital". (When a patient is sent to the Hospital, he is not dropped from the wards population.)

7.0 Sleeping off Ward: This figure reflects the number of assigned patients who are sleeping off ward - either guested on another ward, or working on the grounds housing facilities as details, etc.

8.0 Guest on Ward: This gigure reflects the number of patients being guested on the reporting ward.

9.0 Restraint and Seclusion: These figures are to reflect the total number of patients and the total number of hours in the various types of restraint and seclusion indicated.

10.0 Remarks: This space to be used for signature of Supervisor and Doctors visiting the ward. It may be used to clarify any figures or information listed on the report which may require further explanation.

11.0 New Admissions: List all patients by name and number that are admitted to Sonoma State Hospital and are assigned to the reporting ward. (Not patients returning from an indefinite leave or being received via inter-ward transfer)

12.0 Discharged: List all patients by name and number discharged from Sonoma State Hospital. (Not patients being transferred off the reporting ward or patients leaving ward's population on an Indefinite Leave or U.L.A. status.)

13.0 Expired: List patients by name and number giving exact time of expiration.

14.0 Transferred: To Ward: List patients by name and number being transferred off the ward. If more than one patient is being transferred and they are going to various wards, indicate the ward to which each patient is being sent. If there is not enough space available on the face of the report, turn the paper over and use back of the sheet. Be accurate.

15.0 Transferred: From Ward: Same procedure as 14.0, listing patients transferred to the reporting ward and indicating the ward sending patient (s).

16.0 On Indef. Leave: List patients by name and number who have been released on Indefinite Leave. (i.e. Family Care Home, Home Placement, and Vocational Placement. Clearly indicate type of Indefinite Leave.) Documents must be on the ward supporting this activity. (See page52 A, para. 8.0 for instructions regarding the handling of documents.)

17.0 Return Indef. Leave: List patients by name and number who have been returned to the ward from an Indefinite Leave. (See page 52 A, para. 9.0 for instructions regarding handling of documents.)

18.0 On V. or D.V.: List patients by name and number who have been released on Visit or Definite Visit. Indicate after each name whether patient is on Visit or Definite Visit. Documents must be on the ward supporting this activity. (See page 52, para. 4.0 and 6.0 for instructions regarding handling of documents.)

19.0 Return from V. OR D.V.: List patients by name and number who have been returned from A Visit or Definite Visit. (See page 52, para. 5.0 and page 52 A, para 7.0 for instructions regarding handling of documents.)

20.0 Unauthorized Leave: List any patient by name and number who has been officially put on Unauthorized Leave of Absence.

21.0 Returned from Unauthorized Leave: List any patients by name and number who are returned to population from Unauthorized Leave.

NOTE: The Technician's Daily Report covers the above itemed patient activity for the 24 hour period from 12:00 Midnight to 12:00 Midnight. The ward Charge heads up the report, filling in current information so at the end of the day shift the report reflects all activity to that time. The Night Watch shift is responsible for seeing the report reflects all activity occurring from the end of the day shift til 12:00 Midnight; that the report is correct and all necessary documents are attached. The report is sent to the Division office at Midnight. In reporting activity in paragraphs 12.0 through 21.0 the time is to be noted.

ITEM NUMBERS SHOWN HERE IN RED CORRESPOND TO PARA. NUMBERS ON INSTRUCTION PAGE - 51 & 51-A

TECHNICIAN'S DAILY REPORT

SONOMA STATE HOSPITAL

Ward: _____ Date: _____

V. & D. V.: 1.0 | New Admissions: 11.0

No. of Patients: 2.0

No. of Beds: 3.0

Vacant Beds: 4.0

Excess Patients: 5.0 | Discharged: 12.0 Time: _____

Hospitalized: 6.0

Sleeping off Ward: 7.0

Guest on Ward: 8.0 | Expired: 13.0 Time: _____

Restraint & Seclusion: 9.0

	No. Pts	No.Hrs.
A. Medical Restraint:		
B. Supportive "		
C. Behavioral "		
D. Seclusion		

Transferred: 14.0 To Ward: _____

Transferred: 15.0 From Ward: _____

REMARKS: 10.0

On Indef. Leave: 16.0 Time: _____

Return Indef. Leav : 17.0 Time: _____

On V. Or D.V.: 18.0 Time: _____

Return V. Or D.V.: 19.0 Time: _____

Unauthorized Leave: 20.0 Time: _____

Return Unauthorized Leave: 21.0 Time: _____

Technician in Charge:

A D M I N I S T R A T I V E

NAME

NUMBER

BIRTH DATE

DATE OF ADMISSION

I.Q.

RELIGION

PICTURE

M E D I C A L

RECORD OF CONTINUOUS MEDICATION

NAME
NUMBER

DRUG	DOSAGE	FREQUENCY	DATE ORDERED	D.C.

ANTI-CONVULSANT MEDICATION

MEDICAL ORDER

Name Doe, John Hosp. No. 24680 Birth 2-12-18

Admission Date: 2-20-39 I.Q. 50 M. or F. (1)

Summary of Diagnosis:

Summary of Peculiarities:

Date (2)	DIAGNOSIS (3)	MEDICAL ORDER (4)	Init. (5)	D.C. (6)
INSTRUCTIONS:				
(1) means the sex of the patient - male or female (2) means the date the doctor writes the order (3) diagnosis to be written in by the doctor (4) medical order to be written by the doctor If the doctor gives a verbal order or an order over the telephone, it will be the responsibility of the attendant or nurse to whom the order is given to write the order down on the "Medical Order" sheet. It will be the responsibility of the attendant or nurse in charge of the cottage or ward to insist that the doctor O.K. and initial the order as written by the attendant or nurse the very next time the doctor visits the ward. (5) is the place for the initials of the doctor giving the order (6) is the place for the date on which the doctor orders the medication or treatment to be stopped.			
SAMPLE:				
2-16-50	Epilepsy	Phenobarbital gr. 1as three times a day at 7:30, 12:30 and 5:30 J.A.B.		

Order sheet should be used only to record diagnosis and orders.

Physical findings and History should be recorded on Medical History Sheet.

Current order sheet is kept on top -- previous ones behind it.

SONOMA STATE HOSPITAL

NURSES AND TECHNICIANS NOTES

NAME JONES, Sue Hospital Number 12345

DATE Hour Ward #57 - Slater Cottage

8-28-57	9:00 a.m.	Fell in an epileptic seizure opening an old wound at the base of skull. Dr. X called - ordered patient to hospital where 5 stitches were taken. Patient returned to ward. Doctor ordered 3-day bed rest. Medication changed -- Dilantin gr.***- T.I.D.
		Special Incident Report made on above - (1 original and 3 copies)
10-3-57	8:00 p.m.	Sue has been in an argumentative mood since supper-time. Was resistive and had to be escorted to bed. Was quiet after a short while.
11-13-57	12:30 p.m.	Sue has an eruption on left forearm--Dr.prescribed
	1:00 p.m.	Hot soak to left arm 20 minutes PT
	4:00 p.m.	" " " " " " " PT
	8:00 p.m.	" " " " " " " PT
	8:00 p.m.	Penicillin 600,000 Units RN

Nurses Notes should be kept by Nurses and Technicians as a record of the patient's condition, not only the physical aspects such as temperature, medications, treatments; but also any unusual behavior which might require assistance by either nurse or technician.

SONOMA STATE HOSPITAL

Name Doe, John Hosp. Case No. 000000

Date

HISTORY AND PHYSICAL EXAMINATION DIAGNOSIS

Date and Initial all Entries:

Medical History Sheet for notations by doctors only -- pertinent physical findings or acute illness, etc. It is requested that physicians utilize these sheets rather than recording History and Physical findings on Medical Order Sheet.

Medical History Sheets are to be left in the chart until culled out by Ward Physician.

SAMPLE:

7-10-58 Elevated temp. Noted to have croupy cough. Pharynx mildly infected. Mucopurulent nasal discharge. Ears negative. Chest clear to P.E.A. Abdomen negative.

O.D.

8-11-58 2100 Persistent seizures over past half hour. Temp. normal. Given Sodium Amytal gr. 3 3/4 I.V. with prompt remission of spasm. Chest clear.